

		FOR OHF USE					

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<div>I. IDPH Facility ID Number: 0013334</div> <div>Facility Name: SACRED HEART HOME INC.</div> <div>Address: 1550 S. ALBANY CHICAGO 60623</div> <div>County: COOK</div> <div>Telephone Number: (773) 277-6868 Fax # (773) 277-5014</div> <div>IDPA ID Number: 362707014001</div> <div>Date of Initial License for Current Owners: 01/01/71</div> <div>Type of Ownership:</div> <div><div><div><div>VOLUNTARY,NON-PROFIT</div><div><div>Charitable Corp.</div><div>Trust</div></div><div>IRS Exemption Code</div></div><div><div>X</div><div>PROPRIETARY</div><div><div>Individual</div><div>Partnership</div><div>Corporation</div><div>X"Sub-S" Corp.</div><div>Limited Liability Co.</div><div>Trust</div><div>Other</div></div><div><div>GOVERNMENTAL</div><div><div>State</div><div>County</div><div>Other</div></div></div></div><div>In the event there are further questions about this report, please contact: Name:: Steve Lavenda Telephone Number: (847) 236 - 1111</div></div></div>	<div>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</div> <div>I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/02 to 12/31/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</div> <div>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</div> <div><div>Officer or Administrator of Provider</div><div>(Signed)</div><div>(Type or Print Name)</div><div>(Title)</div></div> <div><div>Paid Preparer</div><div>(Signed) See Accountants' Compilation Report Attached</div><div>(Print Name and Title) JEFFREY K. SINGER, C.P.A.</div><div>(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C. 111 Pfingsten Road, Suite 300 Deerfield, IL 60015</div><div>(Telephone) (847) 236-1111 Fax # (847) 236-1155</div><div>MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</div></div>
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SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

SACRED HEART HOME INC.

#

0013334

Report Period Beginning:

01/01/02

Ending:

12/31/02

III. STATISTICAL DATA					
A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____					
	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	172	Skilled (SNF)	172	62,780	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	172	TOTALS	172	62,780	7

B. Census-For the entire report period.						
	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	52,311			52,311	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	52,311			52,311	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.)

83.32%

SEE ACCOUNTANTS' COMPILATION REPORT

D. How many bed-hold days during this year were paid by Public Aid?
NONE (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒

I. On what date did you start providing long term care at this location?
Date started 7/1/1971

J. Was the facility purchased or leased after January 1, 1978?
YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year?
YES ☐ NO ☒ If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12/31/02 Fiscal Year: 12/31/02

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number SACRED HEART HOME INC. # 0013334 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	191,782	20,669	39,468	251,919		251,919	(518)	251,401			1
2	Food Purchase		323,189		323,189	(35,401)	287,788		287,788			2
3	Housekeeping	269,232	66,199		335,431		335,431	(666)	334,765			3
4	Laundry	6,976	24,398		31,374		31,374	(38)	31,336			4
5	Heat and Other Utilities			124,037	124,037		124,037	1,809	125,846			5
6	Maintenance	205,286	536	177,148	382,970		382,970	5,315	388,285			6
7	Other (specify):*											7
8	TOTAL General Services	673,276	434,991	340,653	1,448,920	(35,401)	1,413,519	5,902	1,419,421			8
	B. Health Care and Programs											
9	Medical Director			700	700		700		700			9
10	Nursing and Medical Records	414,456	25,941	562,581	1,002,978		1,002,978	(2,597)	1,000,381			10
10a	Therapy											10a
11	Activities	113,438	7,142	1,574	122,154		122,154	(292)	121,862			11
12	Social Services	98,595	370	73,331	172,296		172,296	(370)	171,926			12
13	Nurse Aide Training											13
14	Program Transportation			459	459		459		459			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	626,489	33,453	638,645	1,298,587		1,298,587	(3,259)	1,295,328			16
	C. General Administration											
17	Administrative	128,745		618,000	746,745		746,745	(515,504)	231,241			17
18	Directors Fees											18
19	Professional Services			30,899	30,899		30,899	7,178	38,077			19
20	Dues, Fees, Subscriptions & Promotions			5,146	5,146		5,146	575	5,721			20
21	Clerical & General Office Expenses	5,277	39,536	76,040	120,853		120,853	81,294	202,147			21
22	Employee Benefits & Payroll Taxes			147,769	147,769	35,401	183,170		183,170			22
23	Inservice Training & Education											23
24	Travel and Seminar			485	485		485	136	621			24
25	Other Admin. Staff Transportation			784	784		784	3,093	3,877			25
26	Insurance-Prop.Liab.Malpractice			114,609	114,609		114,609	3,746	118,355			26
27	Other (specify):*							38,984	38,984			27
28	TOTAL General Administration	134,022	39,536	993,732	1,167,290	35,401	1,202,691	(380,498)	822,193			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,433,787	507,980	1,973,030	3,914,797		3,914,797	(377,855)	3,536,942			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			73,885	73,885		73,885	(5,352)	68,533			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			3,330	3,330		3,330	21,983	25,313			32
33	Real Estate Taxes							6,205	6,205			33
34	Rent-Facility & Grounds			188,400	188,400		188,400	(188,400)				34
35	Rent-Equipment & Vehicles			13,865	13,865		13,865		13,865			35
36	Other (specify):*											36
37	TOTAL Ownership			279,480	279,480		279,480	(165,564)	113,916			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops			444	444		444		444			40
41	Coffee and Gift Shops		59,105		59,105		59,105	(26,900)	32,205			41
42	Provider Participation Fee			94,170	94,170		94,170		94,170			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		59,105	94,614	153,719		153,719	(26,900)	126,819			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	1,433,787	567,085	2,347,124	4,347,996		4,347,996	(570,319)	3,777,677			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(9,571)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(1,616)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(504)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(16,005)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(57,642)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (85,338)		\$	30

OHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(484,981)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (484,981)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (570,319)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS			Page 5A
SACRED HEART HOME INC.			
ID# 0013334			
Report Period Beginning: 01/01/02			
Ending: 12/31/02			
NON-ALLOWABLE EXPENSES			Sch. V Line
			Amount Reference
1	VENDING	\$ (26,900)	41 1
2	MISCELLANEOUS EXPENSE	(382)	21 2
3	OTHER INCOME	(479)	21 3
4	PPA - NURSING	(2,597)	10 4
5	PPA - DIETARY	(518)	1 5
6	PPA - ACTIVITIES	(292)	11 6
7	PPA - SOCIAL SERVICES	(378)	12 7
8	PPA - OFFICE	(1,526)	21 8
9	PPA - HOUSEKEEPING	(666)	3 9
10	PPA - LAUNDRY	(38)	4 10
11	PPA - MAINTENANCE	(638)	6 11
12	BANK CHARGES	(22,451)	21 12
13	NON-ALLOWABLE AUTO	(784)	25 13
14			14
15			15
16			16
17			17
18			18
19			19
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21			21
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89			89
90			90
91			91
92			92
93			93
94			94
95			95
96			96
97			97
98			98
99			99
100			100
101	Total	(57,642)	101

STATE OF ILLINOIS

Summary B

Facility Name & ID Number SACRED HEART HOME INC. # 0013334 Report Period Beginning: 01/01/02 Ending: 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS
30	Depreciation	(9,571)		4,219									(5,352)
31	Amortization of Pre-Op. & Org.												
32	Interest			21,983									21,983
33	Real Estate Taxes		3,214	2,991									6,205
34	Rent-Facility & Grounds		(188,400)										(188,400)
35	Rent-Equipment & Vehicles												
36	Other (specify):*												
37	TOTAL Ownership	(9,571)	(185,186)	29,193									(165,564)
	Ancillary Expense												
	E. Special Cost Centers												
38	Medically Necessary Transportation												
39	Ancillary Service Centers												
40	Barber and Beauty Shops												
41	Coffee and Gift Shops	(26,900)											(26,900)
42	Provider Participation Fee												
43	Other (specify):*												
44	TOTAL Special Cost Centers	(26,900)											(26,900)
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(85,338)	(185,186)	(441,690)	72,483	69,412							(570,319)

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
PETER O'BRIEN	60.00%	SEE ATTACHED		SEE ATTACHED		
DANIEL O'BRIEN	20.00%					
MARY O'BRIEN	20.00%					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENTAL INCOME	\$ 188,400	LONG TERM CARE, LLP	100.00%	\$	(188,400)	1
2	V	33	REAL ESTATE TAXES				3,214	3,214	2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 188,400			\$ 3,214	\$ * (185,186)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	\$	MADO MGMT. LP	100.00%	\$ 1,809	\$ 1,809	15
16	V	6	REPAIRS AND MAINT.				5,953	5,953	16
17	V	19	PROFESSIONAL FEES				7,178	7,178	17
18	V	20	DUES AND SUBSCRIPTIONS				1,079	1,079	18
19	V	21	CLERICAL AND GENERAL				105,650	105,650	19
20	V	24	SEMINARS				136	136	20
21	V	25	AUTO EXPENSE				3,877	3,877	21
22	V	26	PROPERTY INSURANCE				3,746	3,746	22
23	V	27	GEN. ADMIN. - EMP. BEN.				17,689	17,689	23
24	V	30	DEPRECIATION				4,219	4,219	24
25	V	32	INTEREST				21,983	21,983	25
26	V	33	REAL ESTATE TAXES				2,991	2,991	26
27	V								27
28	V								28
29	V	17	MANAGEMENT FEES	618,000				(618,000)	29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 618,000			\$ 176,310	\$ * (441,690)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	SALARY-D. O'BRIEN	\$	MADO MGMT. LP	100.00%	\$ 6,250	\$ 6,250	15
16	V	27	EMP. BEN.-D. O'BRIEN				3,140	3,140	16
17	V								17
18	V	17	SALARY-P. O'BRIEN				44,444	44,444	18
19	V	27	EMP. BEN.-P. O'BRIEN				6,545	6,545	19
20	V								20
21	V	17	SALARY-C. STUMPF				10,500	10,500	21
22	V	27	EMP. BEN.-C. STUMPF				1,604	1,604	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 72,483	\$ * 72,483	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	\$	MADO MGMT. LP	100.00%	\$	\$	15
16	V	6	REPAIRS AND MAINTENANCE						16
17	V	17	ADMINISTRATIVE SALARY				41,302	41,302	17
18	V	21	CLERICAL SALARY				18,104	18,104	18
19	V	27	GEN. ADMIN. - EMP. BEN.				10,006	10,006	19
20	V	30	DEPRECIATION-WAREHOUSE						20
21	V	33	REAL ESTATE TAXES						21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 69,412	\$ * 69,412	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	DANIEL O'BRIEN	OWNER	Dir. Of Operation	20.00%	SEE ATTACHED	6	15.00%	Alloc. Salary	\$ 6,250	17-7	1
2	DANIEL O'BRIEN	OWNER	Dir. Of Operation	20.00%	SEE ATTACHED	6	15.00%	SALARY	125,000	17-1	2
3	PETER O'BRIEN	OWNER	ADMIN	60.00%	SEE ATTACHED	16	26.66%	Alloc. Salary	44,444	17-7	3
4	CHARLES STUMPF	RELATIVE	ADMIN		SEE ATTACHED	7	15.55%	Alloc. Salary	10,500	17-7	4
5	JAMES WEST	RELATIVE	CLERICAL		SEE ATTACHED	8.9	22.25%	Alloc. Salary	12,226	21-7	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 198,420		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SACRED HEART HOME INC. # 0013334 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

()

()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Ending: 12/31/02

(312) 787-9434

SEE ACCOUNTANTS' COMPILATION REPORT

Ending: 12/31/02

(312) 787-9434

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SACRED HEART HOME INC. # 0013334 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization MADO MGMT. LP
Street Address 1541 N. WELLS ST.
City / State / Zip Code CHICAGO, IL. 60610
Phone Number (312) 787-9400
Fax Number (312) 787-9434

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	DIRECT ALLOCATION		1	2,915				1
2	6	REPAIRS AND MAINTENANCE	DIRECT ALLOCATION		1					2
3	17	ADMINISTRATIVE SALARY	DIRECT ALLOCATION		5	255,302	255,302		41,302	3
4	21	CLERICAL SALARY	DIRECT ALLOCATION		2	218,362	218,362		18,104	4
5	27	GEN. ADMIN. - EMP. BEN.	DIRECT ALLOCATION		5	68,636			10,006	5
6	30	DEPRECIATION-WAREHOUSE	DIRECT ALLOCATION		1	1,082				6
7	33	REAL ESTATE TAXES	DIRECT ALLOCATION		1	1,857				7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 548,154	\$ 473,664		\$ 69,412	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SACRED HEART HOME INC. # 0013334 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

()

()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SACRED HEART HOME INC. # 0013334 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

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Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

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()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SACRED HEART HOME INC. # 0013334 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

()

()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SACRED HEART HOME INC. # 0013334 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

()

()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SACRED HEART HOME INC. # 0013334 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

()

()

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SACRED HEART HOME INC. # 0013334 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

()

()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10		
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense			
		YES	NO				Original	Balance						
	A. Directly Facility Related													
	Long-Term													
1							\$					\$	1	
2													2	
3													3	
4													4	
5													5	
	Working Capital													
6	TIFCO		X	INSURANCE FINANCING								3,330	6	
7													7	
8													8	
9	TOTAL Facility Related						\$					\$	3,330	9
	B. Non-Facility Related*													
10	See Supplemental Schedule												10	
11	ALLOCATED MAD0 MGMT											21,983	11	
12													12	
13													13	
14	TOTAL Non-Facility Related						\$					\$	21,983	14
15	TOTALS (line 9+line14)						\$					\$	25,313	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
1							\$		\$			\$	1
2													2
3													3
4													4
5													5
6													6
7													7
8													8
9													9
10													10
11													11
12													12
13													13
14													14
15													15
16													16
17													17
18													18
19													19
20													20
21							\$		\$			\$	21

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO:

Long Term Care Facilities with Real Estate Tax Rates

RE:

2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

SACRED HEART HOME INC.

COUNTY

COOK

FACILITY IDPH LICENSE NUMBER

0013334

CONTACT PERSON REGARDING THIS REPORT

STEVEN LAVENDA

TELEPHONE

(847) 236-1111

FAX #:

(847) 236-1155

- A. Summary of Real Estate Tax Cost
- Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

(A)	(B)	(C)	(D)
			<u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to Nursing Home</u>
1. <u>16-24-106-035-0000</u>	LONG TERM CARE PROPERTY	\$ <u>408.83</u>	\$ <u>408.83</u>
2. <u>16-24-106-036-0000</u>	LONG TERM CARE PROPERTY	\$ <u>801.28</u>	\$ <u>801.28</u>
3. <u>16-24-106-037-0000</u>	LONG TERM CARE PROPERTY	\$ <u>1,971.23</u>	\$ <u>1,971.23</u>
4. <u>17-04-204-012-0000</u>	HOME OFFICE ALLOCATION	\$ <u>19,785.82</u>	\$ <u>2,990.88</u>
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>22,967.16</u>	\$ <u>6,172.22</u>

- B. Real Estate Tax Cost Allocations
- Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home.
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)
- C. Tax Bills
- Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

IMPORTANT NOTICE

TO:

Long Term Care Facilities with Real Estate Tax Rates

RE:

2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

SACRED HEART HOME INC.

COUNTY

COOK

FACILITY IDPH LICENSE NUMBER

0013334

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ()

FAX #: ()

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

(A)	(B)	(C)	(D)
			<u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to</u>
			<u>Nursing Home</u>
1.		\$	\$
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$	\$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home.
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 79,940

B. General Construction Type: ExteriorFrameNumber of Stories 3

C. Does the Operating Entity?

☐ (a) Own the Facility

☒ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES

☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	FACILITY			\$ 22,077	1
2					2
3	TOTALS			\$ 22,077	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	172		1971	1971	\$ 140,000	\$	35	\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1973	9,000		20	-		9,000	9
10	Various			1975	16,880		20	-		16,880	10
11	Various			1976	4,234		20	-		4,234	11
12	Various			1977	43,234		20	-		43,234	12
13	Various			1978	50,867		20	-		50,867	13
14	Various			1979	40,393		20	-		40,393	14
15	Various			1980	4,392		20	-		4,392	15
16	Various			1981	15,817		20	-		15,817	16
17	Various			1982	15,180		20	-		15,180	17
18	Various			1984	7,505		20	-		7,505	18
19	Various			1985	60,377		20	-		60,377	19
20	Various			1986	41,792		20	-		41,792	20
21	Various			1987	17,344		20	1	1	17,344	21
22	Various			1988	13,840		20	-		13,824	22
23	Various			1989	10,568		20	-		10,568	23
24	Various			1990	48,324		20	1,444	1,444	45,434	24
25	Various			1991	26,113		20	132	132	24,863	25
26	Various			1992	105,671		20	5,284	5,284	83,511	26
27	Various			1993	14,487		20	724	724	13,096	27
28	Various			1994	37,950		20	1,898	1,898	17,082	28
29	Various			1995	38,705		20	1,935	1,935	13,545	29
30	Various			1996	34,431		20	1,721	1,721	12,379	30
31	Various			1997	62,792		20	3,143	3,143	17,137	31
32	Various			1998	73,236		20	3,664	3,664	17,419	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total
SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$ -	\$	\$ -	37
38						-		-	38
39						-		-	39
40						-		-	40
41						-		-	41
42						-		-	42
43						-		-	43
44						-		-	44
45						-		-	45
46						-		-	46
47						-		-	47
48						-		-	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)		71,089	2,386		2,609	223	18,288	68
69	Financial Statement Depreciation			44,211			(44,211)		69
70	TOTAL (lines 4 thru 69)		\$ 1,004,221	\$ 46,597		\$ 22,555	\$ (24,042)	\$ 614,161	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

****Improvement type must be detailed in order for the cost report to be considered complete.**

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 1,057,335	\$ 46,597		\$ 25,210	\$ (21,387)	\$ 623,338	1
2	SMOKE DETECTORS/CCTV	2000	705		20	35	35	102	2
3	GLASS & CLEAR WIRE	2000	505		20	25	25	73	3
4	DOOR	2000	701		20	35	35	79	4
5	WALL GUARD	2000	1,853		20	93	93	279	5
6	FAN FOR HEATER	2000	750		20	38	38	79	6
7	DOORS	2000	544		20	27	27	74	7
8	WIRE GLASS	2000	650		20	33	33	85	8
9	ELECTRICAL	2000	1,450		20	73	73	201	9
10	PAINT	2000	764		20	38	38	98	10
11	PAINT	2000	914		20	46	46	119	11
12	BLINDS	2000	3,356		20	168	168	448	12
13	BASEMENT DOORS	2000	1,223		20	61	61	163	13
14	DOORS & HINGES	2000	501		20	25	25	71	14
15	IRON ON STEPS	2000	1,365		20	68	68	181	15
16	STEPS DEMOLITION	2000	895		20	45	45	116	16
17	CONCRETE	2000	3,750		20	188	188	486	17
18	REPLACE BRICKS	2000	6,000		20	300	300	850	18
19	ROOFING	2000	2,500		20	125	125	344	19
20	ROOFING	2000	2,500		20	125	125	344	20
21	ROOFING	2000	5,250		20	263	263	658	21
22	WIRING	2000	1,000		20	50	50	138	22
23	ALARM PANEL	2000	3,800		20	190	190	523	23
24	ALARM SYSTEM	2000	6,500		20	325	325	840	24
25	COMPRESSOR	2000	2,125		20	106	106	300	25
26	CARPET	2000	1,021		20	51	51	149	26
27	SPRINKLER	2000	544		20	27	27	72	27
28	SPRINKLER	2000	1,551		20	78	78	202	28
29	SPRINKLER	2000	875		20	44	44	110	29
30	GENERATOR	2000	1,832		20	92	92	261	30
31	ELECTRICAL	2000	1,129		20	56	56	168	31
32	DOORS	2000	2,553		20	128	128	384	32
33	DOORS	2000	4,694		20	235	235	607	33
34	TOTAL (lines 1 thru 33)		\$ 1,121,135	\$ 46,597		\$ 28,403	\$ (18,194)	\$ 631,942	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 1,121,135	\$ 46,597		\$ 28,403	\$ (18,194)	\$ 631,942	1
2	DOOR SWEEP	2000	698		20	35	35	88	2
3	DOOR SWEEP	2000	3,408		20	170	170	397	3
4	DOOR SWEEP	2000	701		20	35	35	79	4
5	HOT WATER LINE	2000	1,135		20	57	57	166	5
6	SUMP PUMP	2000	2,236		20	112	112	317	6
7	CAFETERIA A/C	2000	5,030		20	252	252	630	7
8	PLASTER BOARD	2000	3,247		20	162	162	486	8
9	WOOD RAILING	2000	4,293		20	215	215	627	9
10	PLASTER BOARD	2000	1,501		20	75	75	200	10
11	DOORS	2000	1,125		20	56	56	163	11
12	STEPS	2000	17,150		20	858	858	2,145	12
13	STEPS	2000	6,460		20	323	323	808	13
14	ELEVATOR REPAIR	2000	7,860		20	393	393	819	14
15	AIR CONDITIONERS	2001	5,208		20	260	260	390	15
16	VERTICLE BLINDS	2001	1,778		20	89	89	171	16
17	AIR CONDITIONERS	2001	10,403		20	520	520	737	17
18	PIPES & FITTINGS	2001	1,089		20	54	54	108	18
19	CHAINLINK FENCING	2001	1,041		20	52	52	104	19
20	120V COIL	2001	818		20	41	41	79	20
21	RADIATOR CABINET	2001	4,052		20	203	203	389	21
22	HANDRAILS	2001	2,400		20	120	120	220	22
23	HOT WATER LINE	2001	1,460		20	73	73	134	23
24	METAL DOOR	2001	1,327		20	66	66	121	24
25	STEEL PIPE COLUMNS	2001	4,850		20	243	243	425	25
26	FLOOR TILES	2001	10,151		20	508	508	931	26
27	FLOOR TILES	2001	5,890		20	295	295	516	27
28	SECURITY MONITOR	2001	732		20	37	37	65	28
29	SECURITY CAMERAS	2001	1,239		20	62	62	109	29
30	SECURITY MONITOR CAM	2001	1,073		20	54	54	90	30
31	INSTALLED HEATER	2001	670		20	34	34	57	31
32	TUBS	2001	2,256		20	113	113	188	32
33	WATER LINES	2001	11,072		20	554	554	970	33
34	TOTAL (lines 1 thru 33)		\$ 1,243,488	\$ 46,597		\$ 34,524	\$ (12,073)	\$ 644,671	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 1,243,488	\$ 46,597		\$ 34,524	\$ (12,073)	\$ 644,671	1
2	VERTICLE BLINDS	2001	1,778		20	89	89	171	2
3	HANDRAILS	2001	600		20	30	30	48	3
4	FENCE	2001	13,132		20	657	657	821	4
5	ROOF	2001	27,150		20	1,358	1,358	1,584	5
6	FENCE	2001	1,475		20	74	74	80	6
7	HANDRAIL BARS	2001	4,500		20	225	225	244	7
8	ELEVATOR REPAIR	2001	4,324		20	216	216	432	8
9	PAINT	2001	673		20	34	34	68	9
10	PAINT	2001	631		20	32	32	56	10
11	BOILER REPAIR	2001	765		20	38	38	57	11
12	PLUMBING	2001	854		20	43	43	65	12
13	FENCE	2001	7,340		20	367	367	489	13
14	WIRING	2001	1,777		20	89	89	119	14
15	LANDSCAPE ROCKS	2001	500		20	25	25	33	15
16	FENCE	2001	2,142		20	107	107	134	16
17	ELEVATOR REPAIR	2001	726		20	36	36	57	17
18	WATER LINES	2001	2,744		20	137	137	171	18
19	ROOFING MATERIALS	2001	698		20	35	35	41	19
20	SINK	2001	627		20	31	31	36	20
21	COMPRESSOR	2001	1,750		20	88	88	125	21
22	ACCESS LADDERS	2001	3,750		20	188	188	219	22
23	FENCE	2001	1,722		20	86	86	100	23
24	FIXED LADDER GUARD	2001	870		20	44	44	48	24
25	FENCE	2001	2,645		20	132	132	143	25
26	ROOF WORK	2001	975		20	49	49	53	26
27	FENCE	2001	3,235		20	162	162	176	27
28	PAINT	2001	3,033		20	152	152	165	28
29	FIRE SAFETY PAINTING	2001	1,795		20	90	90	98	29
30	CEILING SUPPLIES	2002	552		20	55	55	55	30
31	VERTICAL BLINDS	2002	2,610		20	261	261	261	31
32	DOOR REPAIRS/SMOKE STACK	2002	800		20	73	73	73	32
33	SHOWER PLUMBING	2002	4,690		20	391	391	391	33
34	TOTAL (lines 1 thru 33)		\$ 1,344,351	\$ 46,597		\$ 39,918	\$ (6,679)	\$ 651,284	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

SEE ACCOUNTANTS' COMPILATION REPORT

****Improvement type must be detailed in order for the cost report to be considered complete.**

XI. OWNERSHIP COSTS (continued)
 B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 1,423,393	\$ 46,597		\$ 43,999	\$ (2,598)	\$ 655,365	1
2	PAINTING SUPPLIES	2002	3,944		20	66	66	66	2
3	PARKING LOT REPAIRS	2002	863		20	38	38	38	3
4	PIPE REPAIRS	2002	704		20	18	18	18	4
5	RENOVATION OF STORAGE FLOOR	2002	1,243		20	52	52	52	5
6	REPLACEMENT OF HALLWAY TILES	2002	2,953		20	74	74	74	6
7	ROOF REPAIRS	2002	11,473		20	191	191	191	7
8	SHOWER BASE	2002	1,608		20	107	107	107	8
9	SHOWER REPAIRS	2002	900		20	75	75	75	9
10	SHOWER STALL INSTALLATION	2002	990		20	91	91	91	10
11	SPRINKLER AND PIPE REPAIRS	2002	3,835		20	224	224	224	11
12	SPRINKLER AND REPAIRS	2002	6,430		20	214	214	214	12
13	THERMOSTAT	2002	755		20	57	57	57	13
14	THERMOSTAT	2002	551		20	23	23	23	14
15	TUCKPOINTING	2002	13,900		20	579	579	579	15
16	VENT REPAIRS	2002	545		20	50	50	50	16
17	VERTICAL BLINDS	2002	870		20	36	36	36	17
18	WALLPAPER	2002	2,834		20	1,181	1,181	1,181	18
19	WELDING REPAIRS	2002	869		20	51	51	51	19
20	INDOOR SECURITY CAMERA	2002	5,354		20	268	268	268	20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,484,014	\$ 46,597		\$ 47,394	\$ 797	\$ 658,760	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$ 1,484,014	\$ 46,597		\$ 47,394	\$ 797	\$ 658,760	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,484,014	\$ 46,597		\$ 47,394	\$ 797	\$ 658,760	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 1,484,014	\$ 46,597		\$ 47,394	\$ 797	\$ 658,760	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,484,014	\$ 46,597		\$ 47,394	\$ 797	\$ 658,760	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		\$ 1,484,014	\$ 46,597		\$ 47,394	\$ 797	\$ 658,760	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,484,014	\$ 46,597		\$ 47,394	\$ 797	\$ 658,760	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		\$ 1,484,014	\$ 46,597		\$ 47,394	\$ 797	\$ 658,760	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,484,014	\$ 46,597		\$ 47,394	\$ 797	\$ 658,760	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	FOR OHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4			1988	1988	\$ 46,077	\$ 1,676	35	\$ 1,316	\$ (360)	\$ 9,215	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	ALLOCATED FROM MADO MANAGEMENT			1993	17,551	467	20	878	411	8,270	9
10	ALLOCATED FROM MADO MANAGEMENT			1995	1,069	213	20	54	(159)	401	10
11	ALLOCATED FROM MADO MANAGEMENT			2000	2,625	-	20	131	131	131	11
12	ALLOCATED FROM MADO MANAGEMENT			2001	1,137	30	20	57	(27)	98	12
13	ALLOCATED FROM MADO MANAGEMENT			2002	2,630	-	20	173	173	173	13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total
SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
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58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 71,089	\$ 2,386		\$ 2,609	\$ 169	\$ 18,288	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 206,196	\$ 18,885	\$ 14,461	\$ (4,424)	10	\$ 134,233	71
72	Current Year Purchases	26,711	10,848	1,788	(9,060)	10	1,788	72
73	Fully Depreciated Assets	80,810				10	65,810	73
74								74
75	TOTALS	\$ 313,717	\$ 29,733	\$ 16,249	\$ (13,484)		\$ 201,831	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	FACILITY	1997 JEEP GRAND CHER	1998	\$ 24,457	\$ 1,775	\$ 4,891	\$ 3,116	5	\$ 20,379	76
77										77
78										78
79										79
80	TOTALS			\$ 24,457	\$ 1,775	\$ 4,891	\$ 3,116		\$ 20,379	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,844,265	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 78,105	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 68,534	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (9,571)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 880,970	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	BOILER REPAIR - 1997	\$ 2,297	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 2,297	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ 13,865 Description: SEE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	\$
13.	/2004	\$
14.	/2005	\$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER AIDE

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER AIDE

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.
- SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

12345678										
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	N/A	hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental									13
14	TOTAL			\$		\$	\$		\$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 599	\$ 599	1
2	Cash-Patient Deposits	39,406	39,406	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	366,946	366,946	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	32,609	32,609	6
7	Other Prepaid Expenses	10,414	10,414	7
8	Accounts Receivable (owners or related parties)	4,248,300	5,766,416	8
9	Other(specify): See Supplemental Schedule	5,413	5,413	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,703,687	\$ 6,221,803	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		22,077	13
14	Buildings, at Historical Cost		140,000	14
15	Leasehold Improvements, at Historical Cost	1,084,728	1,084,728	15
16	Equipment, at Historical Cost	320,559	335,559	16
17	Accumulated Depreciation (book methods)	(856,653)	(1,011,653)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Supplemental Schedule			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 548,634	\$ 570,711	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,252,321	\$ 6,792,514	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,117,057	\$ 1,164,329	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	7,782	7,782	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	68,740	68,740	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		3,289	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Supplemental Schedule			36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,193,579	\$ 1,244,140	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Supplemental Schedule			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,193,579	\$ 1,244,140	46
47	TOTAL EQUITY(page 18, line 24)	\$ 4,058,742	\$ 5,548,374	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,252,321	\$ 6,792,514	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 4,381,907	1
2	Restatements (describe):		2
3			3
4	INCOME RESTATEMENT	329,461	4
5	EXPENSE RESTATEMENT	(83,079)	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 4,628,289	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(569,547)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (569,547)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 4,058,742	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SACRED HEART HOME INC.

0013334

Report Period Beginning: 01/01/02

Ending: 12/31/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 3,751,070	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,751,070	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	26,900	12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 26,900	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	479	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 479	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,778,449	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,448,920	31
32	Health Care	1,298,587	32
33	General Administration	1,167,290	33
	B. Capital Expense		
34	Ownership	279,480	34
	C. Ancillary Expense		
35	Special Cost Centers	59,549	35
36	Provider Participation Fee	94,170	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,347,996	40
41	Income before Income Taxes (line 30 minus line 40)**	(569,547)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (569,547)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number SACRED HEART HOME INC.

0013334

Report Period Beginning:

01/01/02

Ending:

12/31/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing			\$	\$	1
2	Assistant Director of Nursing					2
3	Registered Nurses	1,772	1,833	32,210	17.57	3
4	Licensed Practical Nurses	2,374	2,711	37,417	13.80	4
5	Nurse Aides & Orderlies	39,068	43,514	344,829	7.92	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	19,290	20,535	113,438	5.52	10
11	Social Service Workers	11,478	12,508	98,595	7.88	11
12	Dietician	4,881	5,325	36,170	6.79	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	20,262	22,522	155,612	6.91	15
16	Dishwashers					16
17	Maintenance Workers	28,034	30,127	205,286	6.81	17
18	Housekeepers	40,587	43,447	269,232	6.20	18
19	Laundry	1,084	1,209	6,976	5.77	19
20	Administrator					20
21	Assistant Administrator	340	340	3,745	11.01	21
22	Other Administrative	312	312	125,000	400.64	22
23	Office Manager					23
24	Clerical	342	359	5,277	14.70	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>					33
34	TOTAL (lines 1 - 33)	169,824	184,742	\$ 1,433,787 *	\$ 7.76	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	187	\$ 4,681	01-03	35
36	Medical Director	monthly	700	09-03	36
37	Medical Records Consultant	monthly	1,419	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	32	1,574	11-03	44
45	Social Service Consultant	76	4,164	12-03	45
46	Other(specify)				46
47	<u>Outside Labor - Dietary</u>	1,963	34,787	01-03	47
48	<u>Outside Labor - Social Services</u>	3,636	69,167	12-03	48
49	TOTAL (lines 35 - 48)	5,894	\$ 116,492		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	18,683	\$ 459,330	10-03	50
51	Licensed Practical Nurses	2,286	101,832	10-03	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	20,969	\$ 561,162		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions			
Name	Function	Ownership %	Amount	Description		Amount	Description		Amount		
DANIEL O'BRIEN	DIR. OPERATIONS	20.00%	\$ 125,000	Workers' Compensation Insurance		\$ 18,292	IDPH License Fee		\$		
ISABEL AGUILAR	ASST. ADMIN	0	3,745	Unemployment Compensation Insurance		19,786	Advertising: Employee Recruitment		2,727		
				FICA Taxes		109,685	Health Care Worker Background Check		170		
				Employee Health Insurance			(Indicate # of checks performed 15)				
				Employee Meals		35,401	LICENSES AND FEES		1,745		
				Illinois Municipal Retirement Fund (IMRF)*			ALLOCATED MADO MANAGEMENT		1,079		
				401K		6					
TOTAL (agree to Schedule V, line 17, col. 1)											
(List each licensed administrator separately.)			\$ 128,745								
B. Administrative - Other								Less: Public Relations Expense ()			
Description			Amount					Non-allowable advertising ()			
MANAGEMENT FEES			\$ 618,000					Yellow page advertising ()			
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 618,000	TOTAL (agree to Schedule V, line 22, col.8)		\$ 183,170	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 5,721		
(Attach a copy of any management service agreement)											
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**			
Vendor/Payee	Type	Amount		Description	Line #	Amount	Description		Amount		
FR&R	ACCOUNTING	\$	10,150			\$	Out-of-State Travel		\$		
WOLF & COMPANY	ACCOUNTING		4,990								
PERSONNEL PLANNERS	UNEMPLOYMENT CONS.		1,044								
RENITH VILORIA	GENERAL CONSULTING		500				In-State Travel				
ITP GROUP	COMPUTER CONSULTING		6,250								
PETER MURRAY	COMPUTER CONSULTING		1,500								
LAROSE & BOSCO, LTD.	LEGAL		1,649								
HDSI	DATA PROCESSING		4,816				Seminar Expense		485		
							ALLOCATED MADO MANAGEMENT		136		
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	Entertainment Expense ()				
(If total legal fees exceed \$2500 attach copy of invoices.)			\$ 30,899				(agree to Sch. V, line 24, col. 8)				
							TOTAL		\$ 621		

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	n/a		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number		SACRED HEART HOME INC.		STATE OF ILLINOIS				Page 23
		#	0013334	Report Period Beginning:	01/01/02	Ending:	12/31/02	

XX. GENERAL INFORMATION:

(1)

Are nursing employees (RN,LPN,NA) represented by a union?

NO

(2)

Are there any dues to nursing home associations included on the cost report?
If YES, give association name and amount.

NO

(3)

Did the nursing home make political contributions or payments to a political action organization?
If YES, have these costs been properly adjusted out of the cost report?

NO
N/A

(4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?
If YES, what is the capacity?

NO

(5)

Have you properly capitalized all major repairs and equipment purchases?
What was the average life used for new equipment added during this period?

YES
10 YRS

(6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$ 636 Line 10-2

(7)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?
If NO, attach a complete explanation.

YES

(8)

Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease.

NO
N/A

(9)

Are you presently operating under a sublease agreement?

YES X NO

(10)

Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?
If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

YES NO X
N/A

(11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period.
This amount is to be recorded on line 42 of Schedule V.

\$ 94,170

(12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?
If YES, attach an explanation of the allocation.

NO

(13)

Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?

N/A

(14)

Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?
For example, is a portion of the building used for rental, a pharmacy, day care, etc.)
If YES, attach a schedule which explains how all related costs were allocated to these functions.

NO

(15)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.
Has any meal income been offset against related costs?

\$ 35,401
NO
Indicate the amount. \$ N/A

(16)

Travel and Transportation

a.

Are there costs included for out-of-state travel?
If YES, attach a complete explanation.

NO

b.

Do you have a separate contract with the Department to provide medical transportation for residents?
If YES, please indicate the amount of income earned from such a program during this reporting period.

NO
N/A

c.

What percent of all travel expense relates to transportation of nurses and patients?

100% In 14

d.

Have vehicle usage logs been maintained?

N/A

e.

Are all vehicles stored at the nursing home during the night and all other times when not in use?

YES

f.

Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

N/A

g.

Does the facility transport residents to and from day training?
Indicate the amount of income earned from providing such transportation during this reporting period.

NO
\$ N/A

(17)

Has an audit been performed by an independent certified public accounting firm?
Firm Name:
The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached?
If no, please explain.

NO
N/A
N/A

(18)

Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?

YES

(19)

If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report?
Attach invoices and a summary of services for all architect and appraisal fees

N/A

SEE ACCOUNTANTS' COMPILATION REPORT